



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Agency for Healthcare Research and Quality

### Request for Information on Person-Centered Care Planning for Multiple Chronic Conditions (MCC)

**AGENCY:** Agency for Healthcare Research and Quality (AHRQ), HHS.

**ACTION:** Notice of request for information.

**SUMMARY:** The Agency for Healthcare Research and Quality (AHRQ) seeks public comment about comprehensive, longitudinal, person-centered care planning for people with Multiple Chronic Conditions (MCC). Specifically, the RFI seeks comment on the current state of comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC across settings of care (e.g., health systems, primary care, home, and other ambulatory practices), including existing models of person-centered care planning, their current scale, and barriers and facilitators to implementation. In addition, the RFI seeks comments about innovative models of care, approaches, promising strategies and solutions in order for clinicians and practices to routinely engage in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC. This request for information will inform AHRQ's work in improving care for people at risk for or living with MCC.

**DATES:** Comments on this notice must be received by **INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER**. AHRQ will not respond individually to responders but will consider all comments submitted by the deadline.

**ADDRESSES:** Please submit all responses via email to: [MCC@ahrq.hhs.gov](mailto:MCC@ahrq.hhs.gov)

**FOR FURTHER INFORMATION CONTACT:** Poonam Pardasaney, ScD, DPT, MS, Staff Fellow, Phone: (301) 427-1121; Email: [Poonam.Pardasaney@ahrq.hhs.gov](mailto:Poonam.Pardasaney@ahrq.hhs.gov).

**SUPPLEMENTARY INFORMATION:** AHRQ is seeking public comment about comprehensive, longitudinal, person-centered care planning for people at risk for or living with

Multiple Chronic Conditions (MCC). Specifically, AHRQ seeks comment on the current state of comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC across settings of care (e.g., health systems, primary care, home, and other ambulatory practices) including existing models of person-centered care planning, their current scale, and barriers and facilitators to implementation. In addition, AHRQ seeks information about innovative models of care, approaches, and promising strategies and solutions, in order for clinicians and practices to routinely engage in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC. Because it may be possible to prevent or delay the onset of MCC, AHRQ is interested in care planning for those at risk for MCC in addition to those who have MCC. Evidence for effectiveness of strategies for implementation and delivery of person-centered care planning, their impact on improving health outcomes, as well as evidence on how to adapt, scale, and spread the intervention are of interest. For the purposes of this RFI, the following working definitions apply:

Comprehensive, Longitudinal, Person-Centered Care Planning (also known as shared care planning): A process of collaboration among people at risk for or living with MCC, clinicians, and healthcare teams to proactively discuss and record: 1) roles and tasks among care team members, including the individual, their family and caregivers; 2) plans for coordinating care within and across organizations and settings; 3) strategies for supporting and empowering patients to manage their own health; 4) plans for engaging in shared decision making.[1] The care plan should: include all conditions including biomedical and behavioral health conditions; facilitate screening for and/or diagnosing co-existing conditions that impact care management and outcomes, as well as social risks and supports; support evidence-based care; include an individual's goals and preferences; be dynamic and incorporate an approach to updating, as necessary.

Person-Centered Care Plan: A single record of care shared among people at risk for or living with MCC and their clinicians that: 1) is accessible to persons with MCC and their caregivers; 2) puts the person's goals at the center of decision-making; 3) is holistic, including somatic and behavioral health, clinical and nonclinical data, including the social determinants of health; 4) follows the person through both high-need episodes and periods of health improvement and maintenance; 5) allows care team coordination.[2]

Multiple Chronic Conditions (MCC) are defined here as the co-occurrence of two or more chronic physical or behavioral health conditions (including mental health and/or substance use disorders). Some use the term multimorbidity as synonymous with MCC, while others define MCC as including additional factors that contribute to the burden of illness, including disease severity, functional impairments and disabilities, syndromes such as frailty, and sometimes social factors such as homelessness.

#### Importance of Care Planning for People at Risk for or Living With MCC:

Comprehensive, longitudinal, person-centered care planning is central to models of care that deliver high quality care that meet the needs of people at risk for or living with MCC. Person-centered care planning should be designed to achieve the following objectives:

- Prioritize care that maximizes benefits and minimizes harms.
- Incorporate and prioritize competing demands and people's preferences (e.g., morbidity, mortality, burden of care, quality of life).
- Identify roles and tasks among care team members, including the person with MCC.
- Coordinate planning, management and treatment with the whole care network across time and setting (e.g., a multi-disciplinary team, specialty care, community and social services, people with MCC and caregivers) to create and maintain a single plan for each person.
- Elicit and reflect choices and values of people at risk for or living with MCC in the context of their lives.

- Share decision making in a manner that is preferred by people at risk for or living with MCC and caregivers, considering individual values, preferences, cultural, and social contexts.
- Support and empower people at risk for or living with MCC to manage their own health and initiate and sustain behavior change, with the support of their health care team.
- Document specific goals of both people at risk for or living with MCC and their clinicians and health care team and reconcile when necessary.
- Continuously monitor and track progress on goals and preferences through high-need episodes, as well as during periods of health improvement and maintenance, with modification as necessary.
- Is supported by evidence-based clinical guidelines that optimize care for coexisting conditions.
- Ensure equity is adequately addressed to deliver effective person-centered care to all and actively reduce health inequities including among Black, Indigenous, and people of color (BIPOC); socioeconomically disadvantaged individuals; across Sexual Orientation and Gender Identity (SOGI)); for those with low levels of health literacy or limited English proficiency; and for persons with disabilities.

Implementing comprehensive, longitudinal, person-centered care planning requires fundamental changes in the way care is organized and delivered in order to ensure: the active engagement and shared learning of diverse stakeholders; the capacity for timely implementation of rapidly evolving evidence; and innovative approaches to care transformation. While person-centered care planning is practiced in some care settings, it is not routine practice and there are significant evidence gaps regarding the most effective approaches for implementation, scale, and spread. Additionally, the use of shared electronic care plans (e-care plans) can facilitate coordination and communication among people at risk for or living with MCC and their clinicians and health care teams, and provide a shared resource for documenting goals, treatments and supports, education

and self-management, along with other patient-generated health data to support care management.[3]

Who Should Respond?

AHRQ seeks information from:

- Clinicians and other health care personnel who perform some or all key components of comprehensive, longitudinal person-centered care planning for people at risk for or living with MCC, including clinicians and personnel from across all care settings (primary care, specialty care, mental and behavioral health, post-acute care, rehabilitative care, and home and community-based services).
- Researchers and implementers developing interventions to implement person-centered care planning in practice.
- Clinical decision support developers who develop tools for comprehensive, longitudinal person-centered care planning.
- Quality and other measure developers (e.g., metrics, indicators) of person-centered care planning, including process, implementation, and outcomes.
- Patient advocacy groups and organizations.
- Clinical professional societies.
- Payers.
- Healthcare delivery organizations.
- IT Directors who implement and manage health IT and other systems that may support person-centered care planning by people with MCC and their clinicians and health care teams.
- Vendors who develop health IT solutions that facilitate person-centered care planning, including traditional EHR systems, care planning platforms, consumer apps, and other products.

- Organizations that facilitate health information exchange (i.e., regional or local health information exchanges, vendor-driven networks, and others) who may support sharing of care plan information across systems.
- Device developers who incorporate comprehensive longitudinal person-centered care planning into device software.
- People at risk for or living with MCC, their families and caregivers.
- Representatives from human service agencies and/or community organizations, or people with experience in addressing the social determinants of health and reducing disparities for people at risk for or living with MCC.
- Higher education institutions that train clinicians and healthcare personnel and/or train those involved in community health and education.

Specific questions of interest to AHRQ include, but are not limited to, the following:

- What terms, strategies, and models of care are used to describe and deliver care planning for the whole person (not just for individual health conditions) that records: 1) roles and tasks among care team members, including the individual, their family and caregivers; 2) plans for coordinating care within and across organizations and settings; 3) strategies for supporting and empowering patients to manage their own health; 4) plans for engaging in shared decision making?
- What key components are necessary to fully deliver on the promise of person-centered care planning?
- How is comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC currently being done in health systems, primary care, and other ambulatory practices?
- Which organizations are successfully engaged in person-centered care planning for people at risk for or living with MCC?

- Who are the thought leaders in this area and/or where would leaders go to seek information about how to begin this work?
- What are examples of innovative models of care, approaches, promising strategies and solutions that could support clinicians and practices in routinely engaging in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC?
- How are health systems, primary care, and other ambulatory care practices using innovative approaches to implement person-centered care planning for people at risk for or living with MCC?
- What are best practices for designing, implementing, and evaluating person-centered care planning for people at risk for or living with MCC? What implementation challenges are clinicians and systems likely to face?
- What are suggested strategies for effective implementation of person-centered care planning at multiple levels (e.g., policy, system, practice, clinical team, people with MCC)?
- What kinds of information, tools, resources, or support are most needed to address barriers and challenges to implementation?
- Which payment models might enable and sustain person-centered care planning?
- What quality of care measurements (e.g., metrics, indicators) exist or are emerging for assessing process, implementation, and outcomes associated with person-centered care planning?
- Which personnel or roles within systems or practice settings would know most about person-centered care planning efforts, challenges, and successes (e.g., IT directors, c-suite, care coordinators, etc.)?
- Within systems/practice settings, who takes the lead, or would be expected to take the lead, in coordinating efforts to implement person-centered care planning?

- What credentials and/or training of the team members, including paraprofessionals such as community health workers and/or persons with lived experience such as peer recovery specialists are necessary?
- Are there or should there be competency requirements for people engaged in facilitating person-centered planning processes, and what should those entail?
- What are suggested methods for recruiting and retaining the workforce to staff such programs?
- What are the impacts of different models of person-centered care planning on the experience of clinicians and other healthcare personnel, and are increased demands posed by some models precipitating practitioner burnout?
- How have shared electronic care plans (e-care plans) been developed, implemented, and shared with the care team? What are best practices for sharing e-care plans across sites and settings of care?
- What existing and emerging data standards are effectively supporting the interoperability of e-care plans? What key standards gaps around e-care plans should be prioritized by industry and other stakeholders?
- What policy levers should HHS use to further advance the adoption of standards-based e-care plans?
- How can technical approaches using Fast Healthcare Interoperability Resources (FHIR) standards better support sharing of e-care plans across care teams? What are major barriers to advancing these approaches?
- What are best practices for using e-care plans to facilitate communication among people at risk for or living with MCC, their caregivers, clinicians, and health care teams, and provide a shared resource for documenting goals, treatments and supports, education and self-management, along with other patient-generated health data?



- What are promising approaches for systematically identifying and addressing social determinants of health?
- Are there any programmatic adaptations that would address the cultural and linguistic considerations when working with minority populations?
- How can equity be ensured in person-centered care planning?
- What are active areas of research and gaps in knowledge?

AHRQ is interested in all of the questions listed above, but respondents are welcome to address as many or as few as they choose and to address additional areas of interest regarding comprehensive longitudinal person-centered care planning not listed. It is helpful to identify the question to which a particular answer corresponds.

This RFI is for planning purposes only and should not be construed as a policy, solicitation for applications, or as an obligation on the part of the Government to provide support for any ideas in response to it. AHRQ will use the information submitted in response to this RFI at its discretion and will not provide comments to any respondent's submission. However, responses to this RFI may be reflected in future solicitation(s) or policies. The information provided will be analyzed and may appear in reports. Respondents will not be identified in any published reports. Respondents are advised that the Government is under no obligation to acknowledge receipt of the information received or provide feedback to respondents with respect to any information submitted. No proprietary, classified, confidential or sensitive information should be included in your response. The contents of all submissions will be made available to the public upon request. Submitted materials must be publicly available or able to be made public.

1. Burt, J., et al., *Care plans and care planning in long-term conditions: a conceptual model*. Prim Health Care Res Dev, 2014. 15(4): p. 342-54.
2. Baker, A., et al., *Making the Comprehensive Shared Care Plan a Reality*. NEJM Catalyst, 2016.

3. AHRQ. *eCare Plan Joint NIH/NIDDK AHRQ Project*. 9/22/2021; Available from:  
<https://ecareplan.ahrq.gov/>.

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**Marquita Cullom,**  
*Associate Director.*

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